THE PRIVATE INSURANCE MARKET: THE INFLUENCE OF NEW PAYMENT AND DELIVERY MODELS

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Plans Driving a Move Toward Value

- Value Based Benefit Design
- Innovative Payment Models
- Transparency
- Collaborative Provider Partnerships
Delivery and Payment Models—Private Sector Initiatives

*The map is current as of January 2015. As new programs are identified the map will be updated accordingly.*
Key Technical Assistance

• Population Health Management
  o Providing multiple data and report formats, including:
    • Detailed claims data
    • Analytic reports

• Disease and case management/tools for care improvement and decision making
  o Connecting providers with health plans’ disease and case management services by:
    • Embedded nurse case managers
    • Clinical decision-support tools
    • Monthly clinical sessions and collaboration between health plan care management teams and providers

Source: Aparna Higgins, Kristin Stewart, Kirstin Dawson and Carmella Bocchino, Health Affairs, 30, no.9 (2011):1718-1727, Early Lessons From Accountable Care Models In The Private Sector: Partnerships Between Health Plans And Providers
Key Technical Assistance, cont.

- Exchanging health information
  - Two-way flow of information to facilitate case management and clinical decision support

- Managing financial risk
  - Predictive modeling to health access and manage risk; provision of stop-loss coverage or reinsurance

Source: Aparna Higgins, Kristin Stewart, Kirstin Dawson and Carmella Bocchino, Health Affairs, 30, no.9 (2011):1718-1727, Early Lessons From Accountable Care Models In The Private Sector: Partnerships Between Health Plans And Providers
All models have shown Improvement

Quality and Outcomes
• Fewer ER visits; Fewer Readmissions

Improved Patient Satisfaction
• Expanded hours, more timely visits; Use of telehealth

Improved Medical Spend
• Avoided unnecessary costs; Decreased patient OOP

Patient-Centered Medical Home
• $267 million in avoided costs
• Reductions inpatient hospital admissions 3%-42%
• Decrease in ER visits 6%-74%

Accountable Care Models
• Shared savings amounted to > $50 Million
• Increase in quality performance
• Reduction in hospital readmissions by 15%-45%

Episode/Bundled Payment
• Consumers savings of 10-30%
• Estimated overall procedural cost reductions of 34%
• Increased screening rates by 72%
## Framework for Progression of Payment to Clinicians and Organizations in Payment Reform

<table>
<thead>
<tr>
<th>Category 1: Fee for Service – No Link to Quality</th>
<th>Category 2: Fee for Service – Link to Quality</th>
<th>Category 3: Alternative Payment Models on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care</td>
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<td>• Payments still triggered by delivery of services, but, opportunities for shared savings or 2-sided risk</td>
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<td>Examples</td>
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<td>• Some payment is linked to the effective management of a population or an episode of care</td>
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<tr>
<td>Medicare</td>
<td>• Limited in Medicare fee-for-service</td>
<td>• Hospital value-based purchasing</td>
<td>• Accountable Care Organizations</td>
</tr>
<tr>
<td></td>
<td>• Majority of Medicare payments now are linked to quality</td>
<td>• Physician Value-Based Modifier</td>
<td>• Medical Homes</td>
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<tr>
<td></td>
<td></td>
<td>• Readmissions/Hospital Acquired Condition Reduction Program</td>
<td>• Bundled Payments</td>
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<tr>
<td>Medicaid</td>
<td>Varies by state</td>
<td>• Primary Care Case Management</td>
<td>• Integrated care models under fee for service</td>
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<td>• Some managed care models</td>
<td>• Managed fee-for-service models for Medicare-Medicaid beneficiaries</td>
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<td>• Medicaid Health Homes</td>
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Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1 – 4)
- FFS linked to quality (Categories 2 – 4)
- Alternative payment models (Categories 3-4)
Changing the Dynamic of Patient Engagement

- Cost Calculators
- Meaningful Quality Metrics
- Health Decision Assistance
Price Transparency Tools

Aid consumer decision-making and provider selection:
- Estimates of frequency used services, including overall cost and the enrollee’s share of cost;
- Linkage of price information to quality information where available; and
- Network status of providers

Use of mobile apps:
- Member services apps enable enrollees to submit and look up claims, view ID cards, review deductibles, and check account balances.
- Health care management apps enable members to set up preventive care alerts, access personal health records, order Rx refills, track workouts, food intake, and medications.
- Decision-making apps enable members to search for providers and facilities and compare drug costs.
- Medical support apps enable enrollees to contact an RN and access triage services.
Health Plan Mobile Applications

Provides members with access to information:

- Cost estimates – comparing prices of services; Search for providers and facilities
- Access ID card information; View claims and coverage
- Review claims, deductibles, out-of-pocket spending
- Preventive care alerts; Access to personal health records
- Track medications and order prescription refills
- Track workouts and food intake
- Contact with an RN and/or access to Triage services